

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330 To Report Adult Abuse: (800) 564-1612

March 25, 2019

Ms. Erin Barry-Fenton, Manager Loretto Home 59 Meadow Street Rutland, VT 05701-3994

Dear Ms. Barry-Fenton:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 4, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

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Division of Licensing and Protection (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 0138 03/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **59 MEADOW STREET** LORETTO HOME RUTLAND, VT 05701 SUMMARY STATEMENT OF OFFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) IO 10 (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) R100 Initial Comments: R100 An unannounced on-site visit to the facility for Please sel affached Plan of Correction anonymous complaints was conducted by the Division of Licensing and Protection on 3/4/19 and there were regulatory findings. R134 V. RESIDENT CARE AND HOME SERVICES R134 SS=D 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission, consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced Based on staff interview and record review, the facility failed to ensure that 1 of 3 residents in the sample, Resident #1 had an assessment consistent with diagnosis, orders and abilities for medication management within 24 hours and nursing delegation implemented. Findings include: Resident #1 was admitted to the facility on 5/24/18 and there is no evidence in the medical record to indicate that the resident was assessed within 14 days of admission. There is no documentation consistent with diagnosis, orders and abilities for medication management. The resident was admitted from a Residential Care Home, affiliated with the Vermont Catholic Charities organization, that is directly across the street. The Registered Nurse (RN) stated in an Division of Licensing and Protection TITLE

LABORATORY DIRECTOR'S OR PROVINCER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

If continuation sheet 1 of 7

| STATEMEN | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | | E SUR V EY |
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| LORETT | O HOME | | OW STREET), VT 05701 | | | |
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| R134 | Continued From pa | ge 1 | R134 | | , | |
| | resident that was a facility needed to be resident had been a The RN confirmed | that s/he did not realize that a dmitted from the affiliated assessed because the assessed at the other home, at 11:56 AM that an ot done for Resident #1. | | | | |
| R135 \$\$=D | V. RESIDENT CAR | RE AND HOME SERVICES | R135 | | | |
| | 5.5 Assessment | | | | • | |
| · | nursing care, the re licensed nurse with to the home or the | requires nursing overview or esident shall be assessed by a in fourteen days of admission commencement of nursing assessment instrument ensing agency. | | · | | |
| | by: Based on staff interfacility failed to ensing sample, Resident # completed within 1 assessment instruragency. Findings in Resident #1 was ac 5/24/18 and there is record to indicate the assessment complete. | NT is not met as evidenced rview and record review, the ure that 1 of 3 residents in the 1, had an assessment 4 days of admission using an ment provided by the licensing include: dmitted to the facility on is no evidence in the medical mat the resident had an eted within 14 days of sident was admitted from a | | | | |
| | Residential Care H Vermont Catholic C directly across the stated in an intervie realize that a new a | ome, affiliated with the charities organization, that is street. The Registered Nurse w on 3/4/19 that s/he did not assessment needed to be sident came from an affiliated | | | | |

| Division | of Licensing and Pro | otection | | | FORWALL ROVED |
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| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | |
| LORETT | O HOME | 59 MEADO | OW STREET | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTI | ON (X5) |
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| R135 | Continued From pa | ge 2 | R135 | | |
| | | d at 11:56 AM that an ot done for Resident #1. | | | · |
| R145 SS=D | V. RESIDENT CAR | E AND HOME SERVICES | R145 | | |
| ; | 5.9.c (2) | | | | |
| | each resident that i as identified in the of care must descri | ent of a written plan of care for s based on abilities and needs resident assessment. A plan be the care and services the resident to maintain well-being; | | | |
| | by: Based on staff interfacility failed to ensingle, Resident #based on abilities a | NT is not met as evidenced rview and record review, the ure that 1 of 3 residents in the 1, had a written plan of care and needs as identified by the nt. Findings include: | | | |
| | 5/24/18 and there is record to indicate the plan of care based not have a complet utilizing the assess been developed at had lived into prior. The Registered Nu on 3/4/19 at 11:56 / written care plan but | dmitted to the facility on some evidence in the medical mat the resident had a written on needs. The resident did ed assessment and was ment and care plan that had the facility that the resident to admission to the facility, are confirmed in an interview AM, that s/he did not develop a set used the one that came with the other facility and it did not the resident. | | | |

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| | of Licensing and Pro | tection | | | · · · · · · · · · · · · · · · · · · · | - AUDUEN |
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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | СОМ | E SURVEY PLETED |
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| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| LORETTO | O HOME | | OW STREET D, VT 05701 | | | |
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| R150 | Continued From pa | ge 3 | R150 | | | |
| R150 SS=E | V. RESIDENT CAR | E AND HOME SERVICES | R150 | | | |
| | 5.9.c (7) | | : : | | • | |
| | | ems or signs of illness or led at the time of pocurrence, ken; | | | | |
| • | by: Based on staff inte | NT is not met as evidenced rylew and record review, the ure that symptoms or signs of | | , | | |
| | illness were record | ed, along with the action taker, Resident #1 and 2. Findings | ا ۱ | | | |
| | follow up note was record on 3/4/19 at review of the progr | Department (ED) discharge found in Resident #1's medicand it was dated 1/14/19. In ess notes of the facility, there | al | | | |
| | been transferred to for Resident #1. T stated that s/he did | icate why the resident had the ED during record review he Registered Nurse (RN) I not know why the resident | | | | |
| | of the progress no indicate the reside as indicated on the | ed to the hospital and in review tes there are no notes to nt was sent because of a fall, e incident transfer form. | | | | |
| : | #1 was found on the shift on 1/11/19 and | he notes present that Residen ne floor shortly at the change of d there are no follow up notes s condition following the fall. | of | | | |
| | The next note writt indicate that the refor a urinary tract in | en was dated 1/22/19 to sident was started on Bactrim nfection, but there are no note | | | | |
| | symptoms of an in that the resident w | e that the resident had any fection and there are no notes as assessed by the RN. The 1:50 AM that there are no note | | | | |

| | ENT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A BUILDING: | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF | F PROVIDER OR SUPPLIER | STREET AC | ORESS, CITY, ST | TATE, ZIP CODE | |
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| R150 | O Continued From pa | ige 4 | R150 | | |
| | | rare of the hospital transfer not been an assessment of tition. | | | |
| | no evidence that do between 10/23/18 a has a note dated 10 having behaviors a was more depresse appointment for the psych specialist. Twhen or why the rebut there is a note | ical record for Resident #2 has ocumentation was made and 11/30/18. The resident 0/22/18 stating that s/he was nd making claims that s/he ed and there was an e resident to speak with a here is no indication as to sident was sent to the hospital dated 11/30/18 that the ing from the hospital. The RN | | | : : |
| R15 | confirmed at 1:02 F documentation of countries the behaviors or the | | R151 | | : |
| SS=E | 5.9.c (8) | | | | • |
| | Ensure that the res | ident's record documents any ent's condition; | | | |
| | by: Based on staff intel facility failed to ens documents any cha for 3 of 3 residents and 3. Findings ind 1.) An Emergency follow up note was | NT is not met as evidenced review and record review, the ure that the resident's recordinges in a resident's condition in the sample, Resident #1, 2 clude: Department (ED) discharge found in Resident #1's medical and it was dated 1/14/19. In | | | |

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| STATEMEN | T DF DEFICIENCIES DF CDRRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CDNSTRUCTION | (X3) DATE SURVEY CDMPLETED |
| | | · . | | | C. |
| | • | 0138 | B. WING | | 03/04/2019 |
| | OCURACIO DE CUERUSER | STREET AD | UBESS CITY S | TATE, ZIP CODE | |
| NAME OF F | PROVIDER DR SUPPLIER | | OW STREET | 74(2, 2) 0000 | |
| LORETTO | O HOME | | OW 31KEE1 | | |
| · · | DUM MARK OTA | | | PROVIDER'S PLAN OF CORRECTION | ON (X5) |
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| R151 | Continued From pa | nge 5 | R151 | | |
| | review of the progr | ess notes of the facility, there | | | |
| | | icate why the resident had | | | Ì |
| | | the ED during record review | | | |
| | | he Registered Nurse (RN) | | • | |
| • | | I not know why the resident | | | |
| | had been transferre | ed to the hospital and in review | | | |
| | of the progress not | es there are no notes to | : | | \ |
| | | nt was sent because of a fall, | } | | |
| | | incident transfer form. | | | |
| | | ne notes present that Resident | | • | |
| | # Was journo on tr | ne floor shortly at the change of d there are no follow up notes | 1. | | |
| • | ac to the recident's | condition following the fall. | . | , | |
| | . The next note writt | en was dated 1/22/19 to | | | |
| | | sident was started on Bactrim | j | | |
| | | nfection, but there are no notes | ; į | | |
| | to provide evidenc | e that the resident had any | | | |
| | | fection and there are no notes | | | |
| | that the resident w | as assessed by the RN. The | | | |
| | RN confirmed at 1 | 1:50 AM that there are no note: | s ! | | |
| | | ware of the hospital transfer | | | |
| | | not been an assessment of | | | |
| • | the resident's cond | AUOTI. | i | | : |
| | 2) Review of med | ical record for Resident #2 has | 4 | | |
| | | ocumentation was made | | | |
| | | and 11/30/18. The resident | | | |
| | has a note dated 1 | 10/22/18 stating that s/he was | | | |
| | | and making claims that s/he | | | ļ |
| | | sed and there was an | | | : |
| | | e resident to speak with a | | | |
| | | There is no indication as to | ı | | |
| | | esident was sent to the hospita dated 11/30/18 that the | | | |
| | | ning from the hospital. The RN | J | | |
| | | PM that there is no | • | | |
| | | cause or reason surrounding | | | |
| | | ne reason for hospitalization. | | | |
| | The RN further co | infirmed that there had not bee | n | | |

assessment of the resident.

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NOMBER | A BUILDING: | | |
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| NAME OF P | ROVIDER OR SUPPLIER | | DRESS, CITY, ST | ATE, ZIP CODE | |
| LORETTO | HOME | | OW STREET D, VT 05701 | | |
| | O WHIA DV OTA | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTI | ON (X5) |
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| R151 | Continued From pa | age 6 | R151 | | |
| · · | and felt sick and was between 12/16 and the staff had alerte | d reported low grade temps as medicated with Tylenol I 12/18/18. The RN stated that d her that the resident had low s and a cough and that the | | | |
| | resident was havin RN confirms on 3/4 not assessed the n | g behaviors on 12/27/18. The 4/19 at 1:02 PM that s/he had esident and had not made he chart regarding the | : | | |
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Plan of Correction Loretto Home Residence for complaint investigation 3/4/19

R134 VI. Resident Care and Home Services

What action will you take to correct the deficiency?

Director of Nursing will re-educate Loretto's RN assessment nurse regarding timeliness of admission assessments, consistent with the physician's diagnoses and orders. Ensure a written plan of care based on abilities and needs identified by resident assessment. Education will be completed by 4/12.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur?

Administrator will oversee that education and audits are completed. DON will audit all assessments.

R135 V. Resident Care and Home Services

What action will you take to correct the deficiency?

Director of Nursing will re-educate Loretto's RN assessment nurse regarding timeliness of admission assessments, consistent with the physician's diagnoses and orders. Ensure a written plan of care based on abilities and needs identified by resident assessment. Education will be completed by 4/12.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur?

Administrator will oversee that education and audits are completed. DON will audit all assessments.

R145 V. Resident Care and Home Services

What action will you take to correct the deficiency?

Director of Nursing will re-educate Loretto's RN assessment nurse regarding timeliness of admission assessments, consistent with the physician's diagnoses

and orders. Ensure a written plan of care based on abilities and needs identified by resident assessment. Education will be completed by 4/12.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur?

Administrator will oversee that education and audits are completed. DON will audit all assessments. Please refer to attached document.

R150 V. Resident Care and Home Services

What action will you take to correct the deficiency?

Director of Nursing will educate nursing staff about documentation. Education will include to document transfers, explanation of transfer, reason for hospitalization, major status changes, and behaviors. DON will conduct weekly audits, to ensure documentation is completed. Education will be completed by 4/12.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur?

Administrator will oversee that education is completed and weekly audits are completed by DON.

R151 V. Resident Care and Home Services

What action will you take to correct the deficiency?

Director of Nursing will educate nursing staff about documentation. Education will include to document transfers, explanation of transfer, reason for hospitalization, major status changes, and behaviors. DON will conduct weekly audits, to ensure documentation is completed. Education will be completed by 4/12.

What measure will be put into place or systemic changes you will make to ensure that the deficient practice does not occur?

Administrator will oversee that education is completed and weekly audits are completed by DON. Please refer to attached document.

ADMISSION ASSESSMENT AUDIT

| Admission | | ISSION ASSESSIMENT AUDIT | |
|-----------|-------------------|----------------------------|---------------------------------------|
| Date | Resident Name | Date Assessment Completed | Signature |
| Date | Language in Manie | Date Assessment completed. | # Signature Company |
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DOCUMENTATION AUDIT

| Date | Resident Name | What was documented | Signature |
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